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Racism in the medical profession: the experience of UK graduates

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Racism in the medical profession: the experience of UK graduates

June 2003

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This report discusses findings from original research undertaken by the authors. The conclusions are the authors own and **do not necessarily represent BMA policy**.

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Preface

Doctors should be confident in the knowledge that their career progression will be based solely on their abilities, but there is evidence that race can be a barrier to advancement. Inequality of opportunity is a concern that the NHS must take seriously. Discrimination on the grounds of race, gender and disability is illegal and legislation covering sexual orientation and age is due later this year. Moreover, discrimination results in a lack of motivation, frustration and reduced confidence.

This report looks at the experiences and beliefs of one cohort of doctors in relation to racism. It demonstrates that racism does exist in the NHS and is experienced by doctors from ethnic minorities that are UK trained as well as those from overseas. It calls for the profession to demonstrate leadership in excision of racism and for selection procedures to become transparent and based on competency alone.

The BMA, led by the Equal Opportunities Committee, will continue to work towards the removal of discrimination in all its forms. Inequality of opportunity robs the medical profession of talent and is totally unacceptable. A culture of respect and fairness must be developed so that all individuals can feel valued and confident that they will be judged on their capabilities alone.

Dr George Rae
Equal Opportunities Committee Chairman
June 2003

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Summary

Aim

The aim of the study was to explore the nature of racism in the medical profession and to consider remedial strategies.

Method

A survey of 476 UK trained doctors was undertaken as part of the BMA cohort study of 1995 medical graduates. Doctors were asked their views on the extent to which ethnicity was a factor in career progression. Four focus groups involving 33 doctors were used to examine the issue in greater depth.

Findings

In the population of UK graduates racism is manifest in access to training and careers, and in norms of acceptable behaviour. The system is sustained by the reluctance of trainees to complain and the widely held view within the profession that problems encountered by trainees from an ethnic minority are due to valid reasons such as 'not understanding English culture'.

Recommendations

Managers need to ensure that the shortlisting and selection process for training posts is objective and transparent. The profession must show leadership in addressing a professional culture that sustains racism. The government needs to end the artificial competition for postgraduate training by expanding training opportunities in line with the UK's need for trained doctors.

Introduction

This report presents the findings from a survey of 476 doctors on the role of ethnicity in career progression. Four focus groups involving 33 doctors were used to examine the issue in greater depth. The aim of the study was to investigate the nature of racism in the medical profession in order to inform the development of effective policy interventions.

Background

In the UK doctors from an ethnic minority make up 35 per cent of hospital doctors¹. There is evidence that, as a group, doctors who are Black or Asian experience worse terms and conditions of service and opportunities for career progression than White doctors. For example, doctors from an ethnic minority are over-represented in the Staff and Associate Specialist grade (SAS). They currently make up 20 per cent of consultants but 60 per cent of associate specialists and 65 per cent of staff grade doctors².

A recent survey found that a significant minority of doctors in the SAS grade do clinical work comparable to that of a consultant and have operational responsibility for their work. The survey also found that large numbers of doctors in this grade are not being rewarded for their level of qualification (46% of associate specialists and 40% of staff graders hold fellowships of a royal college and/or a CCST), their hours of work (associate specialists are paid for 35 hours but work on average 45; staff graders are paid for 39 but work for 53), or their roles (38% spend 3 hours per week teaching). SAS doctors in accident and emergency, in particular, face long hours and unpredictable shifts. The majority of doctors in this grade do not receive their study leave entitlement, feel frustrated about their lack of career progression and feel their contribution to the NHS is not recognised³.

Perhaps the best known research into the operation of racism in the medical profession is that undertaken by Esmail and Everington^{4,5}. The authors sent matched applications to 50 advertised senior house officer posts. Applications with an Asian name were significantly less likely to be shortlisted than identical applications with an English name. The authors recommended the use of standard and anonymised application forms together with strict enforcement and publication of the results of equal opportunity monitoring.

Despite the evidence provided by Esmail and Everington that ‘people’s careers and livelihoods are jeopardised simply because they have the wrong name (and hence the wrong colour skin)’⁶, the issue is often seen as one of overseas doctors whose career progress is impeded by their lack of language skills, rather than as the result of prejudice. It has also been suggested that the problems of failure to progress and poor treatment are universal for doctors in training^{7,8}. It is hoped that this study may contribute to the debate by addressing the views and experiences of a cohort of UK medical school graduates.

Method

This study forms part of the BMA cohort study, which began in May 1995. An invitation to participate was mailed to all the then final year medical students in the United Kingdom, of whom there were approximately 3,500. A response indicating a willingness to participate was received from approximately 1,400. From these responses, a sample of 600 was drawn using a stratified random sampling strategy.

This was done to ensure that the sample was representative of the population in terms of sex, ethnicity and medical school. The initial questionnaire was mailed in August 1995, around the time of graduation. The mailing received a response rate of 80 per cent, giving a final cohort size of 545.

The collection of data is conducted primarily through a postal questionnaire sent to the 545 participants every August. This process is designed to be both continuous and longitudinal. Information is collected on the preceding 12-month period and linked from year to year using a numerical identifier. This design allows for the career paths of the respondents to be tracked over time.

The annual postal questionnaire is combined with focus groups, which are conducted with a random sub-sample each year. These allow for questions to be examined in greater depth and also serve as a measure of reliability and validity. They also play a role in determining the direction of future research. Care is taken to ensure confidentiality at all times. A full account of the project's methodology is given in the first report.

Response

The 2001 questionnaire received a response from 91 percent of the cohort (496/544¹). Fourteen respondents (4 males, 10 females) were no longer practising medicine and were excluded from the analysis. Six doctors did not respond to the questions on ethnicity. The characteristics of respondents included in the analysis is given in table 1.

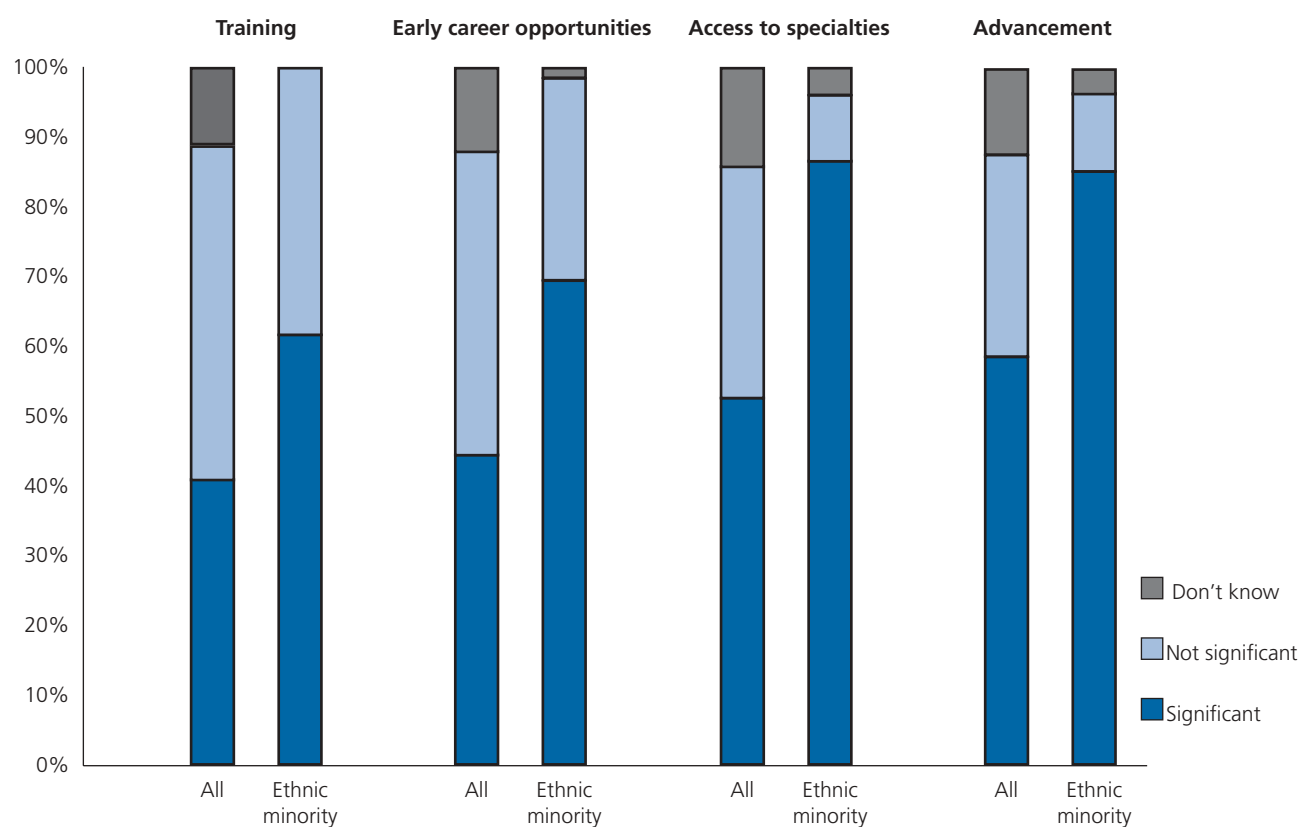
Table 1. Characteristics of survey respondents			
	Male	Female	Total
White	196	204	400
Black Caribbean		2	2
Black African	3		3
Indian	20	15	35
Pakistani	8	2	10
Bangladeshi	1	1	2
Chinese	2	3	5
Other	8	11	19
Total	238	238	476

Focus groups

Four focus groups, consisting of between four and twelve people, were held in London and Leeds in April and May 2002. A random sample of participants from the cohort study were invited to attend a focus group to discuss how gender and ethnicity affected their careers. The focus groups were facilitated by PL and SH and observed by LC. Sessions were taped and transcribed. The characteristics of participants are given in table 2.

Table 2. Characteristics of focus group participants			
	Male	Female	Total
White	15	11	26
Black Caribbean		2	2
Indian	2	2	4
Pakistani	1	1	
Total	18	15	33

Figure 1. Significance of ethnicity for career progression. The graph shows the views of all doctors surveyed (=476) and doctors from an ethnic minority (n=76).



Survey results

Respondents were asked to what extent they thought ethnicity was a factor in career progress. Forty one percent of respondents (196/476) believed ethnicity was significant in medical training, 45% (214/476) in early career opportunities, 53% (254/476) in access to specialties and 59% (281/476) in career advancement. Among doctors from an ethnic minority 62% (47/76) believed ethnicity was significant for medical training, 70% (53/76) for early career opportunities, 87% (66/76) for access to specialties and 86% (65/76) for career advancement (figure 1).

Space was provided for respondents to provide further comments. A frequent comment was that country of qualification, rather than ethnicity per se, was the significant factor. Many respondents said that overseas doctors were discriminated against and ‘had a very raw deal’. Some doctors said that poor language skills among overseas doctors could be a problem. However, other respondents said that they knew of (or had experienced) discrimination on the basis of ethnicity when the language skills of the individual were not known.

Despite the emphasis on the plight of overseas doctors, it was clear that UK graduates from an ethnic minority had also experienced prejudice from colleagues and patients. White doctors also said they had observed discrimination on the basis of ethnicity or overheard racist comments. Frequently white doctors said that it had been ‘easier’ for them to pass exams and to get jobs because they were white. A minority of white, mostly male, doctors said they were unable to comment on the issue of ethnicity because they were white. The following comments were selected to illustrate the range of views.

There is a big difference between UK trained and overseas trained doctors from ethnic minorities. Those from overseas have fewer opportunities when they get here and often end up in non-career grade posts. (British female, White)

Language can be a barrier (and should be!). Very important that language is adequate for good patient communication. (British female, White)

I have attended many interviews as the only Caucasian (with less qualifications) and got the jobs. (British female, White)

I believe that the NHS is another institutionally racist organisation. Being white Caucasian, I have not had direct experience of it; though I have often been in earshot of racist comments (British female, White).

The NHS is a very racist place and mirrors society. Also the referral system favours the status quo. People keep quiet because they want a good reference (British male, Black African).

Depends on who's above you! Influencing how far you get (British female, White).

Yes I have been exposed to racial abuse – from patients, and (directly) from senior medical staff (British male, Pakistani).

Focus group results

During analysis, data from the focus group transcripts were grouped under three broad headings: how racism is manifested in the profession; how the system is sustained; and how the system could be changed.

How is racism manifested in the profession?

Two categories emerged from the focus groups on how racism is manifested: as affecting access to training and career opportunities; and in what is considered acceptable behaviour.

1 Access to training and careers

Focus groups revealed that throughout their education and training participants had been exposed to prejudice from senior members of the profession, often openly admitted. Participants did not feel that prejudice was widespread, rather their experience was of ‘pockets of racism’. Some doctors felt that particular specialties were closed to them due to their ethnic origin. The most frequently expressed view was that in the process of shortlisting and appointing doctors to training posts there was a clear preference for white candidates.

I think I've been lucky in that I've not experienced any racism in my career progression, but then I have a very thick skin and if somebody should say something to me it makes me want to follow my career even more strongly. If somebody does have any negative comments towards me, and I remember when I was a medical student it was one of my obstetric consultants that took me aside after my exam one day and said “You'll never have a training post in this country because of the colour of your skin”, I remember very distinctly what he said and although I don't feel the colour of my skin has affected me at all in my career progression, but the comment he made that day made me even more certain as to what I wanted to do and where I wanted to go. (British male, Pakistani).

I've been told openly, openly by consultants that there is prejudice. I went for a national training number and wasn't shortlisted. I asked for feedback from the people who were shortlisting and one of them said “I chose you for a shortlisting, I'm not prejudiced against you. Unfortunately others are.” (British male, Indian).

Participants repeatedly referred to the opaqueness of the selection process and a system that continued to rely on patronage.

The interview process, even with the structure of the current system, is not transparent. My view is, at a lot of interviews the decision is made before the person's even walked into the room and a lot of the candidates, they're golden boys, they've done the right jobs in the right rotations, they've got the right references and the decision's made before any of the candidates walk into

the room. (British male, Indian).

It's not what you know it's who you know. Certainly in surgery. I know it helped me get the job that I'm in now, without a shadow of a doubt. I've been told by my predecessor that really all I had to do was walk into the interview room and walk out because I'd already got my name on that job, which was very nice for me but it doesn't help the other people I'm competing against, unless they've got equally good backers. I'd like to think I do the job well and deserved that support in the first place, but again the interview process surely is there to try and help the interviewees, to make themselves stand out. It shouldn't be a pre-decided thing, otherwise there's no point in having the interview in the first place, other than to go through the motions. (British male, White)

2 Norms of acceptable behaviour

Participants in the focus groups had observed and directly experienced behaviour that is not considered acceptable in other areas of life and is not tolerated in other work environments.

Well I suppose for me, my main, one example of the many was that the consultant I worked for, where I was going to work for six months, for four months did not know my first name. When asked by the theatre sister who was doing this hysterectomy, he said "The girl will be doing the hysterectomy. I can't remember funny foreign names." I find that quite offensive, in front of me, in front of a theatre full of staff, in front of the anaesthetist, I find that unacceptable, I find it really upsetting. (British female, Indian)

I've certainly been in the situation where I've been sitting doing an intervention list with one of the consultants going through application forms for the next year of the applicants, and he did, he threw out all the ones from overseas, binned them in front of me. (British female, White)

How is the present system sustained?

1 Don't rock the boat

It was clear from focus groups that there exists a code within the profession that doctors in training do not complain. Doctors who do speak up risk jeopardising their future careers.

I think part of the inhibiting process is that you're always applying for jobs and knowing that you've got a job to apply for, and if you upset people at any stage it's very difficult to get other jobs. I know of a couple of chaps who basically complained about their additional duty hours and how they were paid, they will not get a job within the region where I've trained, they managed to win their money but they won't get any jobs, and it's well known. So that's part of the reason why we're so terrible at changing things. (British female, White).

2 Exhaustion

Another reason given by the participants for not doing more to bring about change was that they were often so tired from working that they were unable to consider anything else.

I don't know, it's not playing the game at all, it's working 80 hours a week and being exhausted and that's how people are kept down isn't it, it's a form of torture in some places, that's why people do not speak up, I'm sure that's probably one of the main reasons, that they are just too pushed down by the whole system a lot of the time. (British female, White).

3 Justification for ethnic differences in career progression

Doctors in training are also reluctant to complain because they expect they will be met with the attitude that any problems encountered by doctors from an ethnic minority are due to deficiencies in the candidate, in particular, a lack of social and language skills.

And the other great classic that you hear if you make any sort of complaint in that direction is "Well perhaps you don't understand the English culture well enough". I went to English public school, I understand English culture, I understand English. (British female, Indian)

When I did the membership exam I was told by one of the consultants that the other two candidates who were doing the exams, who were both Caucasian, had better communication skills because they're more English than I am. (British female, Indian)

How could the system be changed?

Participants in the focus groups were also asked to consider how change might be brought about. The following three themes emerged:

- 1 The importance of making the selection process for training posts more transparent and objective.
- 2 The importance of having a personal advocate. This could be, for example, a consultant from a different speciality, to whom a doctor could go without worrying that they were jeopardising their career.
- 3 The importance of changing medical school training, to introduce to the syllabus issues of cultural diversity.

It's very easy to think that cardiothoracics or whatever is male old school tie dominated, but I think it's partly that the old school consultants get on better with little moulds of themselves and they're not quite sure how to deal with someone who doesn't fit into that, so they deal with the people they're comfortable with, they've had a committee meeting from six in the morning, they're going on to do their private work in the evening, they haven't got time or energy to think how the other person will fit in, so it's in a way lack of time discrimination, they don't have the time or the educational training to train people who don't fit into their little box. (British male, White).

Discussion

It is often assumed that problems faced by doctors from an ethnic minority are restricted to 'overseas doctors' who fail to progress due to insufficient language skills. It has also been suggested that trainee doctors may attribute failure to prejudice when in fact it is a common experience in the UK's fiercely competitive system of training and careers. Similarly the poor treatment experienced by doctors from an ethnic minority is said to be no different to the poor treatment of doctors in training generally. This survey counters these assumptions by showing that prejudice on the basis of ethnicity is experienced by UK trained doctors. Our sample included doctors from all ethnic groups and there was universal awareness of racism in the profession.

Since 31 May 2002 trusts have had to comply with the Race Relations (Amendment) Act 2000. Very simply this means eliminating unlawful racial discrimination and promoting equality of opportunity. On the basis of this research managers should take immediate steps to ensure that shortlisting and appointment to medical training posts follow best human resource practice. This study supports the recommendations of Esmail and Everington⁹ that shortlisting should be anonymised.

The profession has recently shown admirable leadership in addressing its 'cultural flaws'¹⁰. Sir Donald Irvine, among others, has called for a 'new professionalism' based on accountability, transparency and responsiveness to patients^{11,12}. The profession must now demonstrate this leadership on the issue of racism, especially in addressing cultural norms regarding acceptable behaviour. Participants felt that culture change could best be brought about through the medical school curriculum, in the discussion of issues of cultural diversity. Some UK universities have already introduced modules on cultural diversity into the undergraduate curriculum. An evaluation of the module used at Leicester University found it was successful in meeting its objectives and engendering positive attitudes toward cultures coming together and about specific cultures¹³. Focus group participants also felt that it was essential that doctors in training have access to an advocate of sufficient authority to be effective but without direct influence on their future careers.

The UK urgently needs more fully-trained doctors yet the numbers of higher specialist training posts has remained static. This environment of artificial competition, where only 'outstanding' candidates have any chance of progress¹⁴, is a breeding ground for prejudice. Opaque selection criteria means that patronage of the 'golden boy', rather than competency, governs progression. If the government is committed to race equality it needs to expand training opportunities in line with the UK's need for senior doctors.

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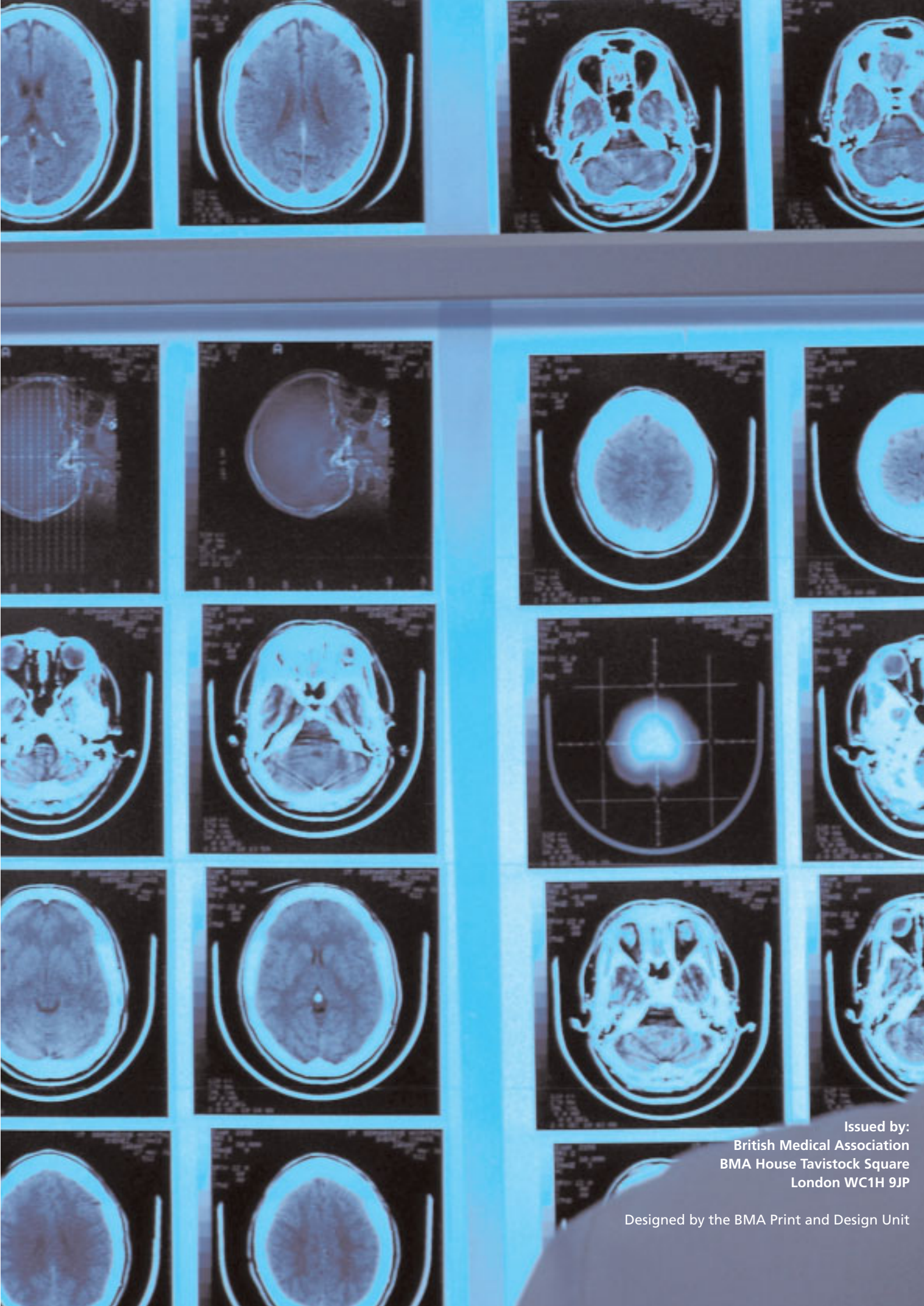
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